

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN0101	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  10/28/2010
NAME OF PROVIDER OR SUPPLIER  BRIARCLIFF HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 100 ELMHURST DR OAK RIDGE, TN 37830		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
N 000	Initial Comments  An annual Licensure survey was completed on October 26 - 28, 2010, at Briarcliff Health Care Center. No deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

*Jodie Jones*

TITLE *Administrator*

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*11-11-10*

STATE FORM

5899

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If continuation sheet 1 of 1